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|---------------------------------|---|-------------------------------|--|
| <i>SERFF Tracking Number:</i> | <i>CEUL-126562874</i> | <i>State:</i> | <i>Arkansas</i> |
| <i>Filing Company:</i> | <i>Family Life Insurance Company</i> | <i>State Tracking Number:</i> | <i>45365</i> |
| <i>Company Tracking Number:</i> | <i>FLEAP-AR</i> | | |
| <i>TOI:</i> | <i>H02I Individual Health - Accident Only</i> | <i>Sub-TOI:</i> | <i>H02I.000 Health - Accident Only</i> |
| <i>Product Name:</i> | <i>Enhanced Accident Policy</i> | | |
| <i>Project Name/Number:</i> | <i>/</i> | | |

Filing at a Glance

Company: Family Life Insurance Company
Product Name: Enhanced Accident Policy
TOI: H02I Individual Health - Accident Only

SERFF Tr Num: CEUL-126562874 State: Arkansas
SERFF Status: Closed-Approved-
Closed

Sub-TOI: H02I.000 Health - Accident Only
Filing Type: Form

Co Tr Num: FLEAP-AR State Status: Approved-Closed
Reviewer(s): Rosalind Minor
Disposition Date: 04/06/2010
Disposition Status: Approved-
Closed

Implementation Date Requested:
State Filing Description:

Implementation Date:

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 04/06/2010

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 03/16/2010
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 04/06/2010
Created By: Lloyd Kleiman
Corresponding Filing Tracking Number:

Deemer Date:
Submitted By: Lloyd Kleiman
Filing Description:

This is a supplemental accident insurance policy that was already approved through our Central United Life Company, we are refiling it via our Family Life Insurance Company.

The Approval date for the Central United Life product is:

3/19/08

Company and Contact

SERFF Tracking Number: CEUL-126562874 State: Arkansas
Filing Company: Family Life Insurance Company State Tracking Number: 45365
Company Tracking Number: FLEAP-AR
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
Product Name: Enhanced Accident Policy
Project Name/Number: /

Filing Contact Information

Lloyd Kleiman, LKleiman@manhattanlife.com
10700 Northwest Freeway 713-529-0045 [Phone] 5184 [Ext]
Houston, TX 77092

Filing Company Information

Family Life Insurance Company CoCode: 63053 State of Domicile: Texas
10700 Northwest Freeway Group Code: 1117 Company Type:
Houston, TX 77092 Group Name: Manhattan Insurance State ID Number:
Group
(800) 877-7705 ext. [Phone] FEIN Number: 91-0550883

Filing Fees

Fee Required? Yes
Fee Amount: \$100.00
Retaliatory? Yes
Fee Explanation: Texas Charges this Amount for Policies.
Per Company: No

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|-------------------------------|----------|----------------|---------------|
| Family Life Insurance Company | \$100.00 | 04/06/2010 | 35425384 |
| Family Life Insurance Company | \$100.00 | 04/06/2010 | 35432559 |

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|--------------------------|--|------------------------|---------------------------------|
| SERFF Tracking Number: | CEUL-126562874 | State: | Arkansas |
| Filing Company: | Family Life Insurance Company | State Tracking Number: | 45365 |
| Company Tracking Number: | FLEAP-AR | | |
| TOI: | H021 Individual Health - Accident Only | Sub-TOI: | H021.000 Health - Accident Only |
| Product Name: | Enhanced Accident Policy | | |
| Project Name/Number: | / | | |

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 04/06/2010 | 04/06/2010 |

Amendments

| Schedule | Schedule Item Name | Created By | Created On | Date Submitted |
|---------------------|---------------------|---------------|------------|----------------|
| Supporting Document | Outline of Coverage | Lloyd Kleiman | 04/06/2010 | 04/06/2010 |

Filing Notes

| Subject | Note Type | Created By | Created On | Date Submitted |
|------------------------|------------------|----------------|------------|----------------|
| Filing fee submitted | Note To Reviewer | Lloyd Kleiman | 04/06/2010 | 04/06/2010 |
| Additional Filing Fees | Note To Filer | Rosalind Minor | 04/06/2010 | 04/06/2010 |

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|---------------------------------|---|-------------------------------|--|
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| <i>TOI:</i> | <i>H021 Individual Health - Accident Only</i> | <i>Sub-TOI:</i> | <i>H021.000 Health - Accident Only</i> |
| <i>Product Name:</i> | <i>Enhanced Accident Policy</i> | | |
| <i>Project Name/Number:</i> | <i>/</i> | | |

Disposition

Disposition Date: 04/06/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

| | | | |
|--------------------------|--|------------------------|---------------------------------|
| SERFF Tracking Number: | CEUL-126562874 | State: | Arkansas |
| Filing Company: | Family Life Insurance Company | State Tracking Number: | 45365 |
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| TOI: | H021 Individual Health - Accident Only | Sub-TOI: | H021.000 Health - Accident Only |
| Product Name: | Enhanced Accident Policy | | |
| Project Name/Number: | / | | |

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|-------------------------------|----------------------------------|----------------------|---------------|
| Supporting Document | Flesch Certification | Approved-Closed | Yes |
| Supporting Document | Application | Approved-Closed | Yes |
| Supporting Document | Health - Actuarial Justification | Approved-Closed | No |
| Supporting Document (revised) | Outline of Coverage | Approved-Closed | Yes |
| Supporting Document | Outline of Coverage | Replaced | Yes |
| Supporting Document | Statement of Variability | Approved-Closed | Yes |
| Form | Enhanced Accident Policy | Approved-Closed | Yes |
| Form | Policy Schedule | Approved-Closed | Yes |
| Form | Rider | Approved-Closed | Yes |
| Form | Notice | Approved-Closed | Yes |

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| <i>Product Name:</i> | <i>Enhanced Accident Policy</i> | | |
| <i>Project Name/Number:</i> | <i>/</i> | | |

Note To Reviewer

Created By:

Lloyd Kleiman on 04/06/2010 01:22 PM

Last Edited By:

Rosalind Minor

Submitted On:

04/06/2010 02:05 PM

Subject:

Filing fee submitted

Comments:

The fee should be updated.

SERFF Tracking Number: *CEUL-126562874* *State:* *Arkansas*
Filing Company: *Family Life Insurance Company* *State Tracking Number:* *45365*
Company Tracking Number: *FLEAP-AR*
TOI: *H02I Individual Health - Accident Only* *Sub-TOI:* *H02I.000 Health - Accident Only*
Product Name: *Enhanced Accident Policy*
Project Name/Number: */*

Note To Filer

Created By:

Rosalind Minor on 04/06/2010 01:08 PM

Last Edited By:

Rosalind Minor

Submitted On:

04/06/2010 02:05 PM

Subject:

Additional Filing Fees

Comments:

Our filing fees under Rule and Regulation 57 has been updated. You may refer to the General Instructions for ArkansasLH or to our Rule and Regulation 57.

The filing fee for this submission is \$50.00 per form for a total of \$200.00. Please submit an additional \$100.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

SERFF Tracking Number: CEUL-126562874 State: Arkansas
Filing Company: Family Life Insurance Company State Tracking Number: 45365
Company Tracking Number: FLEAP-AR
TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only
Product Name: Enhanced Accident Policy
Project Name/Number: /

Amendment Letter

Submitted Date: 04/06/2010

Comments:

There is a minor adjustment to the outline of coverage.

Changed Items:

Supporting Document Schedule Item Changes:

Satisfied -Name: Outline of Coverage

Comment:

AR FLEAP OC.pdf

SERFF Tracking Number: CEUL-126562874 State: Arkansas

Filing Company: Family Life Insurance Company State Tracking Number: 45365

Company Tracking Number: FLEAP-AR

TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only

Product Name: Enhanced Accident Policy

Project Name/Number: /

Form Schedule

Lead Form Number: FLEAP-AR

| Schedule Item | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|-------------------------------|-----------------------|--|-------------------|---------|----------------------|-------------|-------------------------|
| Status | | | | | | | |
| Approved-Closed 04/06/2010 | FLEAP-AR | Policy/Cont ract/Fratern al Certificate | Enhanced Accident | Initial | | | AR FLEAP.pdf |
| Approved-Closed 04/06/2010 | FLEAP-SCH | Schedule Pages | Policy Schedule | Initial | | | FLEAP-SCH.pdf |
| Approved-Closed 04/06/2010 | FLEAP-DR-AR | Policy/Cont Rider ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider | | Initial | | | FLEAP-DR-AR.pdf |
| Approved-Closed 04/06/2010 | FLEAP-AR-Other Not | Notice | | Initial | | | AR Notice(FLEAP).pdf |

**PREMIUM RATES MAY BE CHANGED ON A CLASS BASIS
GUARANTEED RENEWABLE TO AGE 80**

FAMILY LIFE INSURANCE COMPANY

**[10700 Northwest Freeway]
[Houston, Texas 77092]
Customer Service: [(800) 877-7705]**

SUPPLEMENTAL ACCIDENT EXPENSE POLICY

Family Life Insurance Company will be referred to in this Policy as "Company", "We", "Us", and/or "Our". The individual(s) as shown in the Application is referred to in this Policy as "Insured", "You" and/or "Your".

This Policy is issued in consideration of the statements made in the Application and the payment of the premiums specified herein. We hereby insure the Applicant, first named on the Policy Schedule, and all dependent members of the Insured's family, if any, named on the Application (copy of which is attached), and will pay for loss or expense of Accidental Bodily Injuries, as defined herein, which occur while this Policy is in force, subject to all provisions of this Policy.

The first premium is due on the Effective Date. Renewal premiums are due on the same date of each calendar month after the Effective Date. The name, sex and date of birth of the Insured and Effective Date are shown in the Application.

READ YOUR POLICY CAREFULLY

This Policy is a legal contract between You and Us.

SPECIAL NOTICE TO THE APPLICANT

This Policy is issued based on the "Representation and Questions of the Applicant" in the Application for this Policy. If any information shown on it is not correct and complete, or if any past medical history has been left out, write to Us immediately. A copy of Your Application is enclosed. If to Your knowledge, there is any fraudulent misstatement in Your Application or if any relevant part of Your medical history has been omitted, Your Policy may not be a valid contract. The best time to determine this matter is now, *before* a claim arises. If for any reason any such situation exists, contact Us at Our Home Office shown above.

NOTICE OF 10-DAY RIGHT TO EXAMINE POLICY

If this Policy for any reason is unsatisfactory, and within 10 days following receipt thereof it is returned to the Company's Home Office in Houston, Texas, the premium paid will be refunded. If returned, this Policy will be canceled and declared null and void from the Effective Date.

RENEWAL AND PREMIUM PAYMENT PROVISIONS

PREMIUM PAYING PERIOD: This Policy is guaranteed renewable to age 80 by the timely payment of premiums. It must be paid on or before its due date, or within the 31 days that follow. When an Insured's coverage terminates at age 80, coverage for other Insured Persons, if any, shall continue under this Policy. The payment of a premium will not continue this Policy in force beyond the next premium due date. We cannot refuse to renew this Policy or place any restrictions on it if the premium is paid on time.

We may change the premium rates for this Policy. We cannot change the premium rates unless We change them for this Policy form for every Insured in a state in the same class. If We change the premium rates, We will notify the Insured at least 45 days before the change becomes effective. We will notify the Insured at his last known address according to Our records. The initial premium for this Policy is guaranteed not to change for a period of 12 months.

IN WITNESS THEREOF, We have caused this Policy to be signed by Our President and Our Secretary. This Policy takes effect at 12:01 A.M. at Your residence on its Effective Date. This Policy terminates at 12:01 A.M. on the date any renewal premium is due and not paid, subject to the Grace Period.



[Mary Lou Rainey]
Secretary



[Dan George]
President

THIS IS AN ACCIDENT ONLY POLICY AND IT DOES NOT PAY BENEFITS FOR LOSS DUE TO SICKNESS.

TABLE OF CONTENTS

| | |
|------------------------------------|---|
| Definitions..... | 3 |
| Benefits..... | 4 |
| Exclusions and Limitations..... | 5 |
| Termination..... | 5 |
| General Provisions..... | 6 |

DEFINITIONS

A. AMBULATORY SURGICAL CENTER is defined as any licensed public or private establishment with one or more Physicians with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures with continuous Physician services and registered professional nursing services whenever a patient is in the facility and which does not provide services or other accommodations for patients to stay overnight.

B. CHILD OR CHILDREN: unless excluded from coverage, means Your unmarried Children, stepchildren and adopted Children who are dependent on You. They must also be:

- (1) under age 19; or
- (2) under age 25 and enrolled as a full-time student in an accredited school or college.

Children also include any Children for whom You must provide medical support under a court order. A Child is considered Your Child if You have filed a petition to adopt. Also included as Children are grandchildren whom You claim as dependents for federal income tax purposes.

C. COVERED EXPENSES means the dollar amounts listed on health care providers statements, up to the specified limits and maximums shown on the Policy Schedule, which are:

- (1) for Medically Necessary services, supplies, care and treatment;
- (2) due to an Accidental Injury;
- (3) prescribed, performed or ordered by a Physician; and
- (4) incurred while the Insured is covered under this Policy.

D. HOSPITAL is identified as an institution that is licensed as a Hospital and operated pursuant to law. It does not mean to include convalescent homes, convalescent facilities, rest facilities and nursing facilities, home or facilities primarily for the aged, drug addicts, alcoholics, or those primarily affording care for mental or nervous disorders.

E. INJURY or ACCIDENTAL INJURY or ACCIDENTAL BODILY INJURY means physical damage to an Insured Person, which is caused by an injury, sustained on or after the Effective Date, and while this Policy is in force, which is the direct cause of the Loss, independent of disease, bodily infirmity or any other cause.

F. INSURED: If this is an Insured only or Child(ren) only Plan, "Insured" means only the Insured named on the Policy Schedule. If this is a Single Parent, Insured and Spouse or Family Plan, "Insured" means the following provided they are named on the Policy Schedule or added later as provided in the section "Additional Dependents": (1) the Insured; (2) the Insured's spouse; (3) the Insured's unmarried dependent Children who are under age 19 or under age 25 and enrolled as a full-time student in an accredited school or college; and (4) a grandchild who is Your dependent for federal income tax purposes. Coverage shall be provided for an adopted Child of the Insured to the same extent as the coverage provided by this Policy for the Insured's dependent Children.

A Child born to the Insured while this Policy is in force will be covered from the moment of birth, subject to written notice and payment of the applicable premium which must be received by Us within 90 days after such Child's birth.

G. LOSS: For Dismemberment Benefits, "Loss" means: (1) with respect to finger or toe, severance at the joint closest to the wrist or ankle; (2) with respect to hand, or foot, severance at or above the wrist or ankle joint; (3) with respect to arm or leg, severance at or above the shoulder joint or pelvis; (4) with respect to sight, total and permanent blindness.

H. MEDICALLY NECESSARY: A service, type of care or procedure that is specified in a plan of care prepared by a Physician and is appropriate and consistent with the Physician's diagnosis that could not be omitted without adversely affecting the Insured's illness or condition.

I. PHYSICIAN is identified as any licensed practitioner of the healing arts practicing within the scope of his/her license and within the state of his/her licensure.

J. RIGHT OF SUBROGATION means in the event of any payment under this Policy, the Company shall be subrogated to all the Insured's right of recovery therefore against any person or organization for negligence or any willful act resulting in Injury for which benefits are provided hereunder, but only to the extent of the benefits as provided. The Insured shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The Insured shall do nothing after the Loss for which such payment was incurred to prejudice such rights.

BENEFITS

PART I - ACCIDENTAL DEATH

If an Accidental Bodily Injury results in the loss of life of the Insured Person within 90 days of the accident causing such Injury, the Company will pay the Accidental Death Benefit shown on the Policy Schedule. The Accidental Death Benefit shall be paid to the Beneficiary, if any, otherwise to the estate of the Insured. No claim for this benefit will be denied wherein the Insured Person, with the use of extraordinary life support systems delays the Loss for more than 90 days from the date of the accident.

PART II – MEDICAL EXPENSE BENEFIT

If, as the result of Accidental Bodily Injury, an Insured Person requires medical treatment, the Company will pay for Covered Expenses which are incurred within 28 calendar days of the accident causing the Injury. The maximum benefit amount payable for any one accident for the Insured Person shall not exceed the Medical Expense Benefit shown on the Policy Schedule.

For medical treatment received by the Insured Person on an outpatient basis, Covered Expenses include Physician Charges, Surgery, X-rays, Reduction of Fractures or other emergency first-aid expenses incurred in a Physician's Office, Clinic, Outpatient Hospital Facility or Ambulatory Surgical Center which are incurred within 28 calendar days of the accident causing such Injury. If Covered Expenses are incurred at a Hospital emergency room, a \$50 deductible will apply for each Accidental Injury.

For medical treatment received by the Insured Person confined in a Hospital as a resident bed patient, Covered Expenses include Physician charges, Hospital room and Medically Necessary Hospital billed services and supplies which are incurred within 28 calendar days of the accident causing such Injury.

PART III – DAILY HOSPITAL CONFINEMENT BENEFIT

If, as the result of Accidental Bodily Injury, the Insured Person is Hospital confined, the Company will pay the Daily Hospital Confinement Benefit shown on the Policy Schedule for each day of such confinement, up to a maximum of 30 days of Hospital confinement resulting from any one accident.

PART IV – AIR AND GROUND AMBULANCE BENEFIT

If, as a result of Accidental Bodily Injury, an Insured Person requires Medically Necessary air or ground ambulance transportation to or from a Hospital, We will pay the Covered Expenses for such transportation which occurs within 28 calendar days of the accident causing such Injury. The maximum Air or Ground Ambulance Benefit payable for any one accident is shown on the Policy Schedule.

PART V – ACCIDENTAL DISMEMBERMENT BENEFIT

If an Accidental Bodily Injury results in Loss of finger, toe, hand, arm, foot, leg or sight of an Insured Person within 90 days of the accident causing such Injury, the Company will pay the Accidental Dismemberment Benefit shown in the Policy Schedule. No claim for this benefit will be denied wherein the Insured Person, with the use of extraordinary life support systems delays the Loss for more than 90 days from the date of the accident.

The total amount payable for all Losses resulting from the same accident will not exceed the Maximum Dismemberment Benefit Per Accident shown in the Policy Schedule.

EXCLUSIONS AND LIMITATIONS

Benefits otherwise provided by this Policy will not be payable for services or expenses or any such Loss resulting from or in connection with:

- (1) sickness, illness or bodily infirmity;
- (2) suicide, attempted suicide or intentional self-inflicted Injury, whether sane or insane;
- (3) dental care or treatment due to accidental Injury to natural teeth;
- (4) war or any act of war (whether declared or undeclared) or participating in a riot or felony;
- (5) alcoholism or drug addiction;
- (6) travel or flight in any aircraft or device which can fly above the earth's surface in any capacity other than as a fare paying passenger on a regularly scheduled airline;
- (7) the Insured's commission or attempt to commit a felony or to which a contributing cause was the Insured's being engaged in an illegal occupation;
- (8) the Insured Person's being intoxicated or under the influence of any narcotic or controlled or uncontrolled substance unless administered on the advice of a Physician; or
- (9) charges incurred outside the U.S. if an Insured traveled to the location for the purpose of receiving medical services, drugs or supplies.

DEATH OF INSURED/TERMINATION OF POLICY

This Policy is made with the Insured who has signed the Application heretofore. Such Insured is the Beneficiary of all Insured Persons, and every transaction relating to this Policy shall be between the Company and such Insured. In the event of death of such Insured, the spouse, if an Insured Person, shall automatically become the Insured and Beneficiary of all Insured Persons.

The spouse of the Insured shall cease to be an Insured Person at the end of the term during which the spouse becomes divorced or legally separated from the Insured. The spouse shall be eligible for a Conversion Policy, at attained age and without evidence of insurability, then in use by the Company which most closely approximates the coverage provided by this Policy. Written request for conversion and payment of the first premium must be made within 31 days after termination of insurance under this Policy.

The covered dependent Children of the Insured shall cease to be Insured Persons at the end of the term during which they have reached the limiting age or marry.

The attainment of the limiting age for a covered dependent will not cause coverage to terminate while that person is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent on You for support and maintenance. Chiefly dependent means the covered dependent receives the majority of his/her financial support from You.

We will request in writing, and at Our expense, that You provide proof that the dependent is in fact a disabled and dependent person. In the absence of such proof, We may terminate the coverage of such person after the attainment of the limiting age.

Termination of this Policy shall be without prejudice to any continuous loss that commenced while the policy was in force. The extension of benefits beyond the period the policy was in force is subject to the continuous total disability of the insured person and is limited to the duration of the policy benefit period or payment of the maximum benefits.

GENERAL PROVISIONS

ENTIRE CONTRACT: This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After 2 years from the Effective Date of this Policy, no misstatement, except fraudulent misstatements, made by the Applicant in the Application for such Policy shall be used to void this Policy or to deny a claim for Loss incurred commencing after the expiration of such 2 year period.

GRACE PERIOD: A Grace Period of 31 days will be granted for the payment of each premium falling due after the first premium, during which Grace Period this Policy shall continue in force.

REINSTATEMENT: If any renewal premium is not paid within the time granted the Insured for payment, a subsequent acceptance of premium by the Company or by any agent duly authorized by the Company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate this Policy provided, however, that if the Company or such agent requires an application for reinstatement, this Policy will be reinstated upon approval of such Application by the Company or, lacking such approval, upon the 45th day following the date of such Application, unless the Company has previously notified the Insured in writing of its disapproval of such Application. The reinstated Policy shall cover only Loss resulting from such Accidental Injury as may be sustained after the date of reinstatement. In all other respects the Insured and Company shall have the same rights thereunder as they had under this Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

NOTICE OF CLAIM: Written Notice of Claim must be given to the Company within 20 days after the occurrence or commencement of any Loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Insured or the Beneficiary to the Company at Houston, Texas, or to any authorized agent of the Company, with information sufficient to identify the Insured, shall be deemed notice to the Company.

CLAIM FORMS: The Company, upon receipt of a Notice of Claim, will furnish to the claimant such forms as are usually furnished by it for filing Proof of Loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to Proof of Loss upon submitting, within the time fixed in this Policy for filing Proof of Loss, written proof covering the occurrence, the character and the extent of the Loss for which claim is made.

PROOF OF LOSS: Written Proof of Loss must be furnished to the Company at its said office within 90 days after the date of such Loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as is reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this Policy for any Loss will be paid immediately upon receipt of due written proof of such Loss.

PAYMENT OF CLAIMS: Indemnity for Loss of life will be payable in accordance with the Beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Insured. Any other accrued indemnities unpaid at the Insured's death may, at the option of the Company, be paid either to such Beneficiary or to such estate. All other indemnities will be payable to the Insured. If any indemnity of this Policy shall be payable to the estate of the Insured, or to an Insured or Beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding \$1,000.00 to any relative by blood or connection by marriage to the Insured or Beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment. The Company retains the Right of Subrogation.

Upon the death of the Insured, the proceeds payable to the Insured or his or her estate under this Policy shall include premiums paid for this Policy for any period beyond the end of the Policy month in which death occurred. Such unearned premiums will be paid in a lump sum on a date no later than 30 days after the proof of the Insured's death has been furnished to the Company.

PHYSICAL EXAMINATION AND AUTOPSY: The Company at its own expense shall have the right and opportunity to examine the person of the Insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTION: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written Proof of Loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of 3 years after the time written Proof of Loss is required to be furnished.

CHANGE OF BENEFICIARY: Unless the Insured makes an irrevocable designation of Beneficiary, the right to change of Beneficiary is reserved to the Insured and the consent of Beneficiary or Beneficiaries shall not be requisite to surrender or assignment of this Policy or to any change of Beneficiary or Beneficiaries, or to any other changes in this Policy.

ADDITIONAL DEPENDENTS: Anyone who becomes a spouse or dependent Child of the Insured after the Effective Date of this Policy may be added by making written Application, providing evidence of eligibility and insurability satisfactory to the Company and upon payment of any required premium. The acceptance of additional dependents will be shown by an endorsement affixed to this Policy and the date of such endorsement shall be the Effective Date under this Policy with respect to such additional dependents.

With respect to a newborn Child, coverage is effective from the moment of birth for a period of 90 days without evidence of insurability or acceptance by the Company. After 90 days, such Child will remain a named dependent only if written notice of birth is received by the Company and any required premium is paid for such dependent.

An adopted Child's coverage is effective on the date of the filing of a petition for adoption if the Insured provides the Company written notice of the child and has paid any additional required premium for such child within 60 days after the filing of the petition for adoption. If the Insured provides the Company written notice and pays any additional required premium for such child within 60 days after the birth of the adopted child, coverage for such child is effective on the moment of birth.

OTHER INSURANCE IN THIS COMPANY: Insurance effective at any one time on the Insured under a like Policy or policies in this Company is limited to one such Policy elected by the insured, his Beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

UNPAID PREMIUM: Upon payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

CONFORMITY WITH STATE STATUTES: Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Insured resides on such date, is hereby amended to conform to the minimum requirements of such state.

FAMILY LIFE INSURANCE COMPANY
[10700 Northwest Freeway, Houston, Texas 77092]
[Customer Service: (800) 877-7705]

POLICY SCHEDULE
SUPPLEMENTAL ACCIDENT EXPENSE POLICY

| | |
|---------------------|---------------------|
| Primary Insured: | Issue Age: |
| Insured Dependents: | Mode of Payment: |
| Policy Number: | First Renewal Date: |
| Effective Date: | Initial Premium: |

POLICY

| | |
|------------------------------------|---|
| Units Purchased | [.5; 1; 1.5; 2] |
| Accidental Death Benefit | [\$25,000; \$50,000; \$75,000; \$100,000] |
| Medical Expense Benefit | [\$1,000; \$2,000; \$3,000; \$4,000] |
| Daily Hospital Confinement Benefit | [\$75; \$150; \$225; \$300] |
| Air or Ground Ambulance Benefit | [\$2,500; \$5,000; \$7,500; \$10,000] |
| Accidental Dismemberment Benefit | |
| Loss of Finger or Toe | |
| Single Loss Benefit | [\$250; \$500; \$750; \$1,000] |
| Multiple Loss Benefit | [\$500; \$1,000; \$1,500; \$2,000] |
| Loss of Hand, Arm, Foot, Leg | |
| Single Loss Benefit | [\$2,500; \$5,000; \$7,500; \$10,000] |
| Multiple Loss Benefit | [\$5,000; \$10,000; \$15,000; \$20,000] |
| Loss of Sight | |
| Single Loss Benefit | [\$2,500; \$5,000; \$7,500; \$10,000] |
| Multiple Loss Benefit | [\$5,000; \$10,000; \$15,000; \$20,000] |
| Maximum Dismemberment Per Accident | [\$5,000; \$10,000; \$15,000; \$20,000] |

OPTIONAL BENEFIT FOR ACCIDENT DISABILITY INCOME RIDER [Yes; No]

| | |
|------------------------|------------------------------------|
| Units Purchased | [.5; 1; 1.5; 2] |
| Monthly Income Benefit | [\$500; \$1,000; \$1,500; \$2,000] |
| Elimination Period | 30 Days |
| Maximum Benefit Period | [6; 12; 18; 24] Months |

FAMILY LIFE INSURANCE COMPANY
[10700 Northwest Freeway]
[Houston, Texas 77092]

ACCIDENT DISABILITY INCOME BENEFIT RIDER

In consideration of the payment of premium for this Rider, this Rider is attached to and made a part of the Policy to which it is attached.

DEFINITIONS

ELIMINATION PERIOD means the selected days at the beginning of Your covered Total Disability for which no benefit is payable.

GROSS INCOME means earned income, including salaries or wages, bonuses, commissions and any other compensation the Insured receives or is entitled to receive from daily vocational efforts.

Gross income does not include unearned income, such as investment income, royalties, gifts or annuities received independently of daily occupational efforts.

TOTAL DISABILITY or **TOTALLY DISABLED** means that You are completely and continuously unable to perform all the substantial and material duties of Your job or a comparable job and are not engaged in any employment or occupation for wage or profit. Disability causing Total Disability must require the regular care and attendance of a Physician.

BENEFITS

MONTHLY BENEFITS FOR INJURY. When We receive proof that You are Totally Disabled as a result of Injury as defined herein, We will pay beginning with the first day of Total Disability following the Elimination Period, the Monthly Benefit Income amount shown in the Policy Schedule for each month, not to exceed 60% of Your Gross Income. If You are continuously Totally Disabled, benefits are payable for the Maximum Benefit Period shown in the Policy Schedule and will end on the earlier of:

1. the date the Maximum Benefit Period ends; or
2. the date You attain age 65.

You must be continually Totally Disabled during the Elimination Period and as long as benefits are payable.

BENEFITS FOR LESS THAN A MONTH. Total Disability for less than a month will be paid at a daily rate of one-thirtieth of the Monthly Benefit.

SUCCESSIVE DISABILITIES. Successive periods of Total Disability shall be considered to be one period of Total Disability subject to the Maximum Benefit Period unless the subsequent period of Total Disability is due to a bodily Injury entirely unrelated to the cause or causes of the previous periods of Total Disability and it commences after You have returned to and have been actively at work for at least 4 weeks.

GENERAL PROVISIONS

PAYMENT OF CLAIMS: For Accident Disability Income Claims, all benefits will be paid to You. Any benefits unpaid at Your death will be paid to Your estate. If any benefit of this Policy shall be payable to Your Estate, the Company may pay such benefit, up to an amount not exceeding \$1,000.00 to any relative by blood or connection by marriage to the Insured who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment. The Company retains the Right of Subrogation.

CLAIM CONDITIONS:

1. You must undergo a medical examination, functional capacity examination and/or psychiatric examination, including any related test as are reasonably necessary to the performance of the examination or specialist for the condition at such time and place and with such frequency as We reasonably require. We reserve the right to select the examiner. We will pay for the examination, including the costs associated with travel to the examination, if the examination cannot be conducted locally.
2. You must meet with Our representative for a personal interview or review of records at such time and with such frequency, as We reasonably require. We reserve the right to have phone interviews and answers to written questions.
3. We must be given the information, which We need to determine if a benefit is payable and how much that benefit should be. We may require relevant portions of Your federal income tax returns for You or Your business.

CHANGE OF OCCUPATION: If You are injured after You change Your occupation stated in this Policy or on the Application to one classified by Us as more hazardous than the occupation stated in this Policy or while doing for compensation anything pertaining to an occupation so classified, We will pay only the portion of the indemnity provided in this Policy as the premium paid would have purchased at the rates and within the limits fixed by Us for the more hazardous occupation. If You change Your occupation to one classified by Us as less hazardous than the occupation stated in this Policy, We, upon receipt of the proof of change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of occupation or from the Policy anniversary date immediately preceding the receipt of proof, whichever is more recent.

TERMINATION

This Rider will terminate on the earliest of:

1. the date You reach age 65;
2. the date of Your retirement; or
3. the date the Policy to which this Rider is attached terminates.

Termination will be without prejudice to any continuous claim which commenced while this Rider was in force until the earliest of:

1. the period of time equal to the time this Rider was in force;
2. the date You are no longer Totally Disabled; or
3. the date the Maximum Benefit Period ends.

This Rider is subject to all of the conditions, limitations and definitions of the Policy to which it is attached. In all other respects Your coverage remains the same.



[President]

FAMILY LIFE INSURANCE COMPANY
[10700 Northwest Freeway]
[Houston, Texas 77092]

IMPORTANT INFORMATION

If You have questions about Your Policy or a claim You have filed, please contact Your insurance company or Your agent:

FAMILY LIFE INSURANCE COMPANY
[10700 Northwest Freeway]
[Houston, Texas 77092]
[(800) 877-7705]

Agent: _____

Address: _____

Telephone: _____

If We at Family Life Insurance Company fail to provide You with reasonable and adequate service, You should feel free to contact the Arkansas Department of Insurance at:

Arkansas Department of Insurance
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Telephone: (501) 371-2640

| | | | |
|--------------------------|--|------------------------|---------------------------------|
| SERFF Tracking Number: | CEUL-126562874 | State: | Arkansas |
| Filing Company: | Family Life Insurance Company | State Tracking Number: | 45365 |
| Company Tracking Number: | FLEAP-AR | | |
| TOI: | H021 Individual Health - Accident Only | Sub-TOI: | H021.000 Health - Accident Only |
| Product Name: | Enhanced Accident Policy | | |
| Project Name/Number: | / | | |

Supporting Document Schedules

| | | Item Status: | Status Date: |
|------------------------------|--------------------------|-----------------|-----------------|
| Satisfied - Item: | Flesch Certification | Approved-Closed | 04/06/2010 |
| Comments: | | | |
| Attachment: | | | |
| fleapflcert_001.pdf | | | |
| | | | |
| | | Item Status: | Status Date: |
| Satisfied - Item: | Application | Approved-Closed | 04/06/2010 |
| Comments: | | | |
| Attachment: | | | |
| FLIC-ESAE-0310.pdf | | | |
| | | | |
| | | Item Status: | Status Date: |
| Satisfied - Item: | Outline of Coverage | Approved-Closed | 04/06/2010 |
| Comments: | | | |
| Attachment: | | | |
| AR FLEAP OC.pdf | | | |
| | | | |
| | | Item Status: | Status Date: |
| Satisfied - Item: | Statement of Variability | Approved-Closed | 04/06/2010 |
| Comments: | | | |
| Attachment: | | | |
| Statement of Variability.pdf | | | |

FAMILY LIFE

Lloyd Kleiman
Compliance Analyst

March 29, 2010

I, Mary Lou Rainey, Secretary for Central United Life Insurance Company, hereby certify that the following form(s) has the following readability score as calculated by the Flesch Reading Ease Test set forth by your state, and meets the minimum reading ease requirements set forth by the state of Arkansas.

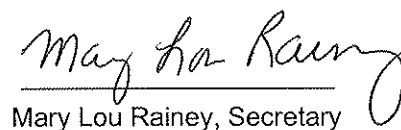
FORM

Readability Score

FLEAP-AR
FLEAP-OC-AR
FLEAP-DR-AR
FLIC-ESAE-0310
Policy Schedule
FLEAP-APP-Not

51.6

DATE: 3/29/10


Mary Lou Rainey, Secretary

10700 Northwest Freeway
Houston, Texas 77092
Email: lkleiman@manhattanlife.com

Phone: 713-529-0045, ext. 5184
Toll Free: 800-669-9030 ext. 5184
Fax: 713-821-6551



FAMILY LIFE INSURANCE COMPANY

[10700 Northwest Freeway, Houston, Texas 77092]

Application for: Enhanced Supplemental Accident Expense Policy

Requested Effective Date: _____

PART 1 - GENERAL INFORMATION

1. PERSONS TO BE COVERED

| Name (Please PRINT Full Name) | Relationship | Gender | Date of Birth | Age | Height Ft. In. | Weight Lbs. | Social Security Number |
|-------------------------------|--------------|--------|---------------|-----|----------------|-------------|------------------------|
| 1. | Applicant | | | | | | - - |
| 2. | Spouse | | | | | | - - |
| 3. | Child | | | | | | - - |
| 4. | Child | | | | | | - - |
| 5. | Child | | | | | | - - |

2. APPLICANT'S HOME ADDRESS

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Email Address: _____

3. PREMIUM PAYOR ADDRESS (if different than Applicant)

Premium Payor Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

4. EMPLOYMENT INFORMATION (All adult applicants)

Employer's Name: _____

Occupation/Duties: _____

Spouse's Employer's Name (if applying): _____

Spouse's Occupation/Duties: _____

5. BENEFIT INFORMATION: Accident Policy

Benefit Amount: Medical Expense Benefit

☐ .5 Unit ☐ 1.0 Unit ☐ 1.5 Unit ☐ 2.0 Units
[\$1,000] [\$2,000] [\$2,500] [\$3,000]

Plan Type: ☐ Individual ☐ Individual & Spouse
☐ Single Parent ☐ Family ☐ Child(ren) Only

Billing Method: ☐ Monthly Bank Draft ☐ Direct Bill ☐ List Bill

Billing Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

6. OPTIONAL RIDER: Accident Disability Rider Yes ☐ No ☐

Occupation: ☐ Type 1 ☐ Type 2

Benefit Amount: Accident Disability Monthly Income Benefit

☐ .5 Unit ☐ 1.0 Unit ☐ 1.5 Unit ☐ 2.0 Units
[\$500] [\$1,000] [\$1,500] [\$2,000]

Units elected for Optional Accident Disability Rider may be less than or equal to but cannot exceed the number of units elected for the Accident Policy.

7. BENEFICIARY

Name: _____

Relationship: _____

8. PRIMARY PHYSICIAN

Name: _____

Address: _____

Phone: _____

PART 2 - REPRESENTATION & QUESTIONS OF THE APPLICANT

| | YES | NO |
|---|--------------------------|--------------------------|
| 1. Are all persons to be insured to the best of your knowledge and belief in good health and free from physical impairment or abnormality? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2a. Is any person to be insured engaged in any hazardous sports or activities including racing, but not limited to parachuting, rodeo riding, mountain climbing, scuba diving or intend to do so? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2b. Is any person to be insured a member/participant in a semi-professional or professional sport? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3a. Have you had a driver's license suspended or revoked within the past 3 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3b. Have you had a DWI or DUI within the past 3 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3c. Is any person to be insured currently under treatment or has any person to be insured been under treatment for drug or alcohol abuse in the past 3 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are all persons to be insured ages 19 to 25 years old enrolled as a full time student in an accredited school or college? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is there any other health, accident or disability insurance in force on the proposed insured? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Will the insurance applied for replace or change any existing insurance? | <input type="checkbox"/> | <input type="checkbox"/> |

If YES, give name of Company and type of insurance: _____

If Bank
Draft
Authorization,
ATTACH VOIDED
CHECK HERE
and sign
authorization
at right.

AUTHORIZATION TO MY BANK

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks drawn on my account by and payable to the order of the Family Life Insurance Company, Houston, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. A photocopy of my signature should be honored as if it were original. Requested Draft Date: _____

Date _____ X _____ Signature (as it appears on bank records) _____

AUTHORIZATION FOR PAYROLL DEDUCTION

Employee _____ I hereby authorize _____
Name Name of Employer

to deduct from my salary and pay to Family Life Insurance Company, [Houston, Texas], the monthly deposits as set forth below. Beginning with the month of, _____ 20 _____ \$ _____ each month.
Month

Signature of Employee _____

Date _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

- A. I hereby authorize and request any physician, hospital, dentist, pharmacy, individual, employer, insurance company, law enforcement agency, governmental agency or other entity to permit bearer or representative of Family Life Insurance Company to view, copy, be furnished a copy or be given details of all record information in connection with any past or present illnesses, financial records, employment records and/or police records. This authorization is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug and alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or sexually transmitted diseases. The results of an HIV-related test shall be confidential and we cannot release or disclose this information except in the circumstances permitted by state and federal law.
- B. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, my employer, the Medical Information Bureau, Inc. ("MIB") or consumer reporting agency or insurance company who possesses information of care, treatment or advice of me, my family, or our health may furnish such information to Family Life Insurance Company or its representative or its reinsurers upon presenting this authorization or a photocopy.
- C. Family Life Insurance Company or its reinsurers may make a brief report available regarding me or my dependents to other companies to whom I have applied or may apply.
- D. This authorization will be valid from the date signed for a period of two and one half years.
- E. I authorize Family Life Insurance Company to obtain an investigative consumer report on me.

Dated: _____ Dated at: _____

Signed X _____ Signed X _____
Signature of Proposed Insured Signature of Spouse

APPLICANT'S STATEMENT

I hereby apply to Family Life Insurance Company for a policy to be issued in reliance on my written answers to the foregoing questions. I understand that: (a) the policy of insurance I am now applying for will be issued solely upon the written answers to questions and information asked for in this application; (b) the agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (c) the policy with this application and any endorsements, riders or other papers, if any, is the entire contract of insurance; and (d) no change to the policy will be valid until approved by an officer of the Company which must be noted on or attached to the policy. I have read, or have read to me, the completed application and realize policy issuance is based upon statements and answers provided herein and they are complete and true to the best of my knowledge and belief. I acknowledge I have received an Outline of Coverage for the policy applied for.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact or material thereto commits a fraudulent insurance act, which may be a crime as determined by a court of law.

I understand that if the Accident Disability Income Benefit Rider is elected, the maximum benefit per month will not exceed 60% of my gross monthly income.

Dated at _____ on _____ 20 _____.
City, State & Zip Month & Day

Signature of Applicant: _____ Signature of Spouse: _____

AGENT'S STATEMENT

I Certify: 1) That any information recorded by me is true and correct to the best of my knowledge and belief. 2) I have given an outline of coverage for the policy applied for to the Applicant. 3) This ☐ does ☐ does not replace other insurance.

Dated _____ on _____ 20 _____.
City, State & Zip Month & Day

Agent Name (Print) _____

Agent Signature _____

Agent Number _____

FAMILY LIFE INSURANCE COMPANY

[10700 Northwest Freeway]

[Houston, Texas 77092]

SUPPLEMENTAL ACCIDENT EXPENSE COVERAGE POLICY FORM FLEAP-AR

REQUIRED OUTLINE OF COVERAGE

PARAGRAPH 1

Read your Policy Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY.**

PARAGRAPH 2

This Policy is designed to provide you with coverage for (death, dismemberment, disability or hospital and medical care) resulting from a covered accident only. Coverage is provided for the benefits outlined in paragraph (3). The benefits described in paragraph (3) may be limited by paragraph (4).

PARAGRAPH 3

BENEFITS

PART I - ACCIDENTAL DEATH

If an Accidental Bodily Injury results in the loss of life of the Insured Person within 90 days of the accident causing such Injury, the Company will pay the Accidental Death Benefit shown on the Policy Schedule. The Accidental Death Benefit shall be paid to the Beneficiary, if any, otherwise to the estate of the Insured. No claim for this benefit will be denied wherein the Insured Person, with the use of extraordinary life support systems delays the Loss for more than 90 days from the date of the accident.

PART II – MEDICAL EXPENSE BENEFIT

If, as the result of Accidental Bodily Injury, an Insured Person requires medical treatment, the Company will pay for Covered Expenses that are incurred within 28 calendar days of the accident causing the Injury. The maximum benefit amount payable for any one accident for the Insured Person shall not exceed the Medical Expense Benefit shown on the Policy Schedule.

For medical treatment received by the Insured Person on an outpatient basis, Covered Expenses include Physician Charges, Surgery, X-rays, Reduction of Fractures or other emergency first-aid expenses incurred in a Physician's Office, Clinic, Outpatient Hospital Facility or Ambulatory Surgical Center which are incurred within 28 calendar days of the accident causing such Injury. If Covered Expenses are incurred at a Hospital emergency room, a \$50 deductible will apply for each Accidental Injury.

For medical treatment received by the Insured Person confined in a Hospital as a resident bed patient, Covered Expenses include Physician charges, Hospital room and Medically Necessary Hospital billed services and supplies that are incurred within 28 calendar days of the accident causing such Injury.

PART III – DAILY HOSPITAL CONFINEMENT BENEFIT

If, as the result of Accidental Bodily Injury, the Insured Person is Hospital confined, the Company will pay the Daily Hospital Confinement Benefit shown on the Policy Schedule for each day of such confinement, up to a maximum of 30 days of Hospital confinement resulting from any one accident.

PART IV – AIR AND GROUND AMBULANCE BENEFIT

If, as a result of Accidental Bodily Injury, an Insured Person requires Medically Necessary air or ground ambulance transportation to or from a Hospital, We will pay the Covered Expenses for such transportation which occurs within 28 calendar days of the accident causing such Injury. The maximum Air or Ground Ambulance Benefit payable for any one accident is shown on the Policy Schedule.

PART V – ACCIDENTAL DISMEMBERMENT BENEFIT

If an Accidental Bodily Injury results in Loss of finger, toe, hand, arm, foot, leg or sight of an Insured Person within 90 days of the accident causing such Injury, the Company will pay the Accidental Dismemberment Benefit shown in the Policy Schedule. No claim for this benefit will be denied wherein the Insured Person, with the use of extraordinary life support systems delays the Loss for more than 90 days from the date of the accident.

The total amount payable for all Losses resulting from the same accident will not exceed the Maximum Dismemberment Benefit Per Accident shown in the Policy Schedule.

PARAGRAPH 4 EXCLUSIONS AND LIMITATIONS

Benefits otherwise provided by this Policy will not be payable for services or expenses or any such Loss resulting from or in connection with:

- (1) Sickness, illness or bodily infirmity;
- (2) Suicide, attempted suicide or intentional self-inflicted Injury, whether sane or insane;
- (3) Dental care or treatment due to accidental Injury to natural teeth;
- (4) War or any act of war (whether declared or undeclared) or participating in a riot or felony;
- (5) Alcoholism or drug addiction;
- (6) Travel or flight in any aircraft or device which can fly above the earth's surface in any capacity other than as a fare paying passenger on a regularly scheduled airline;
- (7) The Insured's commission or attempt to commit a felony or to which a contributing cause was the Insured's being engaged in an illegal occupation;
- (8) The Insured Person's being intoxicated or under the influence of any narcotic or controlled or uncontrolled substance unless administered on the advice of a Physician; or
- (9) Charges incurred outside the U.S. if an Insured traveled to the location for the purpose of receiving medical services, drugs or supplies.

PARAGRAPH 5 OPTIONAL BENEFIT RIDER (Available with additional premium)

Accident Disability Income Benefit Rider: Pays the Monthly Income Benefit (not to exceed 60% of the Insured's gross income) on a weekly basis, beginning on the day following the Elimination Period up to the Maximum Benefit Period. Benefits are provided under this Rider for the Primary Insured only. No benefits are provided under this Rider for the spouse or dependent Children, if any, covered under the Policy.

PARAGRAPH 6 RENEWABILITY

This Policy is Guaranteed Renewable to age 80.

PARAGRAPH 7 PREMIUM

Your premium for the policy is \$_____ annually. If your premium is not annual, it is \$_____ for _____ months. The Policy provides a 31-day grace period during which period the Policy will remain in force. Premiums are subject to change.

FAMILY LIFE INSURANCE COMPANY
Administrative Office
10700 Northwest Freeway
Houston, TX 77092
Customer Service: (800)-877-7705

Statement of Variability

Company Address (administrative office): is variable and will only change if our administrative office moves from the current address. We will, of course, provide appropriate notice to the department in the event of an address change.

Officer's Signature: Is variable and will only change in the event that our officers change. We will provide appropriate notice in the event of an officer change.

Plan Benefits(policy): Although unlikely, the pre-selected plan offering benefit amounts may change, however, the plans were originally filed with dollar amounts per unit of the various benefits, and also with a maximum number of units. We will not change or exceed those limits as originally filed without first pursuing approval with your department.

Plan Benefits(rider): Same explanation as for policy. We will not alter or exceed amounts filed with the initial filing of the riders.

| | | | |
|---------------------------------|---|-------------------------------|--|
| <i>SERFF Tracking Number:</i> | <i>CEUL-126562874</i> | <i>State:</i> | <i>Arkansas</i> |
| <i>Filing Company:</i> | <i>Family Life Insurance Company</i> | <i>State Tracking Number:</i> | <i>45365</i> |
| <i>Company Tracking Number:</i> | <i>FLEAP-AR</i> | | |
| <i>TOI:</i> | <i>H021 Individual Health - Accident Only</i> | <i>Sub-TOI:</i> | <i>H021.000 Health - Accident Only</i> |
| <i>Product Name:</i> | <i>Enhanced Accident Policy</i> | | |
| <i>Project Name/Number:</i> | <i>/</i> | | |

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

| Creation Date: | Schedule | Schedule Item Name | Replacement Creation Date | Attached Document(s) |
|----------------|----------|---|------------------------------|---------------------------------|
| 03/29/2010 | | Supporting Outline of Coverage Document | 04/06/2010 | AR FLEAP OC.pdf (Superseded) |

FAMILY LIFE INSURANCE COMPANY

[10700 Northwest Freeway]

[Houston, Texas 77092]

SUPPLEMENTAL ACCIDENT EXPENSE COVERAGE POLICY FORM EAP-AR

REQUIRED OUTLINE OF COVERAGE

PARAGRAPH 1

Read your Policy Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY.**

PARAGRAPH 2

This Policy is designed to provide you with coverage for (death, dismemberment, disability or hospital and medical care) resulting from a covered accident only. Coverage is provided for the benefits outlined in paragraph (3). The benefits described in paragraph (3) may be limited by paragraph (4).

PARAGRAPH 3

BENEFITS

PART I - ACCIDENTAL DEATH

If an Accidental Bodily Injury results in the loss of life of the Insured Person within 90 days of the accident causing such Injury, the Company will pay the Accidental Death Benefit shown on the Policy Schedule. The Accidental Death Benefit shall be paid to the Beneficiary, if any, otherwise to the estate of the Insured. No claim for this benefit will be denied wherein the Insured Person, with the use of extraordinary life support systems delays the Loss for more than 90 days from the date of the accident.

PART II – MEDICAL EXPENSE BENEFIT

If, as the result of Accidental Bodily Injury, an Insured Person requires medical treatment, the Company will pay for Covered Expenses that are incurred within 28 calendar days of the accident causing the Injury. The maximum benefit amount payable for any one accident for the Insured Person shall not exceed the Medical Expense Benefit shown on the Policy Schedule.

For medical treatment received by the Insured Person on an outpatient basis, Covered Expenses include Physician Charges, Surgery, X-rays, Reduction of Fractures or other emergency first-aid expenses incurred in a Physician's Office, Clinic, Outpatient Hospital Facility or Ambulatory Surgical Center which are incurred within 28 calendar days of the accident causing such Injury. If Covered Expenses are incurred at a Hospital emergency room, a \$50 deductible will apply for each Accidental Injury.

For medical treatment received by the Insured Person confined in a Hospital as a resident bed patient, Covered Expenses include Physician charges, Hospital room and Medically Necessary Hospital billed services and supplies that are incurred within 28 calendar days of the accident causing such Injury.

PART III – DAILY HOSPITAL CONFINEMENT BENEFIT

If, as the result of Accidental Bodily Injury, the Insured Person is Hospital confined, the Company will pay the Daily Hospital Confinement Benefit shown on the Policy Schedule for each day of such confinement, up to a maximum of 30 days of Hospital confinement resulting from any one accident.

PART IV – AIR AND GROUND AMBULANCE BENEFIT

If, as a result of Accidental Bodily Injury, an Insured Person requires Medically Necessary air or ground ambulance transportation to or from a Hospital, We will pay the Covered Expenses for such transportation which occurs within 28 calendar days of the accident causing such Injury. The maximum Air or Ground Ambulance Benefit payable for any one accident is shown on the Policy Schedule.

PART V – ACCIDENTAL DISMEMBERMENT BENEFIT

If an Accidental Bodily Injury results in Loss of finger, toe, hand, arm, foot, leg or sight of an Insured Person within 90 days of the accident causing such Injury, the Company will pay the Accidental Dismemberment Benefit shown in the Policy Schedule. No claim for this benefit will be denied wherein the Insured Person, with the use of extraordinary life support systems delays the Loss for more than 90 days from the date of the accident.

The total amount payable for all Losses resulting from the same accident will not exceed the Maximum Dismemberment Benefit Per Accident shown in the Policy Schedule.

PARAGRAPH 4 EXCLUSIONS AND LIMITATIONS

Benefits otherwise provided by this Policy will not be payable for services or expenses or any such Loss resulting from or in connection with:

- (1) Sickness, illness or bodily infirmity;
- (2) Suicide, attempted suicide or intentional self-inflicted Injury, whether sane or insane;
- (3) Dental care or treatment due to accidental Injury to natural teeth;
- (4) War or any act of war (whether declared or undeclared) or participating in a riot or felony;
- (5) Alcoholism or drug addiction;
- (6) Travel or flight in any aircraft or device which can fly above the earth's surface in any capacity other than as a fare paying passenger on a regularly scheduled airline;
- (7) The Insured's commission or attempt to commit a felony or to which a contributing cause was the Insured's being engaged in an illegal occupation;
- (8) The Insured Person's being intoxicated or under the influence of any narcotic or controlled or uncontrolled substance unless administered on the advice of a Physician; or
- (9) Charges incurred outside the U.S. if an Insured traveled to the location for the purpose of receiving medical services, drugs or supplies.

PARAGRAPH 5 OPTIONAL BENEFIT RIDER (Available with additional premium)

Accident Disability Income Benefit Rider: Pays the Monthly Income Benefit (not to exceed 60% of the Insured's gross income) on a weekly basis, beginning on the day following the Elimination Period up to the Maximum Benefit Period. Benefits are provided under this Rider for the Primary Insured only. No benefits are provided under this Rider for the spouse or dependent Children, if any, covered under the Policy.

PARAGRAPH 6 RENEWABILITY

This Policy is Guaranteed Renewable to age 80.

PARAGRAPH 7 PREMIUM

Your premium for the policy is \$_____ annually. If your premium is not annual, it is \$_____ for _____ months. The Policy provides a 31-day grace period during which period the Policy will remain in force. Premiums are subject to change.